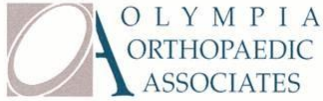




Complete Entire Section/Please Print Clearly			
Date:	Male ____ Female ____	Date of Birth:	Patient Social Security Number
Patient Name (Last, First, Middle):		Home Phone:	Cell Phone:
Address: State/Apt #: _____ City: _____ State: _____ Zip: _____			
Employment Information:			
Patient Employer Name:		Occupation:	Work Number:
Complete if the responsible party is different from patient			Emergency Contact (outside of Home)
Spouse/Parent/Legal Guardian:			Emergency Contact Name:
Social Security Number:	Phone:	Relationship to Patient:	
Address:	Work Phone Number:	Contact Phone Number:	
Authorized/Unauthorized Person(s) to Release Personal Account Information			
Name:	Circle One: Release/Deny	Security Question (fill in one or all) Favorite Color	
Name:	Release/Deny	Mothers Maiden Name:	
Name:	Release/Deny	City of Birth:	
Primary Care and Referring Doctor Information			
Primary Care Physician (Name, Address, Phone #):		Referring Doctor (Name, Address, Phone #)	
Reason for Visit, Body Region:		Side Affected: Lt. _____ Rt. _____ Bilateral _____	
		Onset Date: ____/____/____	
***Insurance Information: ____ Please check if you have no insurance			
Primary Insurance Company:	Subscriber Name:	Insurance ID #:	Group #:
Secondary Insurance Company:	Subscriber Name:	Insurance ID #:	Group #:
State/Self Insured Workman's Comp (Name, Address, Phone #)	Claim #	Date of Injury:	
Authorization for Release of Medical Records: We must have your authorization to release medical information to your insurance carrier or physician for payment upon request. My signature verifies that authorization.			
Medicare-Lifetime Authorization: I authorize Medicare benefits be made to me or on my behalf to my physician for any services furnished to me by that physician. I authorize any holder of my medical information to release any information to the health care financing administration and its agents that may be needed to determine these benefits or the benefits payable for related services. I hereby authorize medicare to furnish the above named doctor any information regarding my Medicare claims in title XVII of the Social Security Act.			
Referral: I understand that it is my obligation to obtain a referral for any services if one is required by my insurance. This referral may also require approval by my primary care doctor. If I fail to provide an appropriate referral, I accept full responsibility for any charges incurred in the course of treatment.			
Guarantee of Eligibility: I understand I am financially responsible for any balance not covered by my insurance carrier. I also understand that should I provide incorrect or untimely information regarding my primary care provider, my insurance coverage, or if I am not eligible under the terms of my medical subscriber agreement, I am liable for all charges for services rendered. A copy of this signature is valid as the original.			

Patient/Responsible Party: _____ Date: _____



MEDICAL HISTORY FORM

Name: _____ Today's Date: _____

Age _____ Sex: M or F (circle) Height _____ Weight _____ Are You: left or right handed (circle)

Occupation: _____ Primary Care Physician: _____

Past Medical History: Do you have or have you ever had: Please circle

High Blood Pressure	Y N	Hepatitis	Y N	Sleep Apnea	Y N	Cancer	Y N
Diabetes	Y N	Do you take Insulin	Y N	Heart Disease	Y N	Angina	Y N
Arthritis	Y N	Stroke	Y N	MRSA	Y N	Asthma	Y N
Thyroid Condition	Y N	Stomach Ulcers	Y N	GI Disease	Y N	Gout	Y N

Other Medical Conditions not listed above:

Prior Surgeries: (Type of surgery; date of surgery)

Present Medications: (Name of medication; Strength/dosage; How often taken)

Are You Taking Blood Thinners? Y N Please circle: Coumadin Plavix Warfarin Aspirin

Medication Allergies: (Indicate medication and type of reaction)

Have you had ANY reactions to pain medications? (Nausea, vomiting, etc...) If yes which medications?

Do you have an allergy to Latex? Y N Do you have an allergy to Metal? Y N

Habits: Smoking Y N How Much? _____ Alcohol Y N How Much? _____

Family History: Is there a family history of Diabetes, Heart Disease, Cancer, other Diseases?

System Review: Do you experience any of the following problems? Please circle

Fever	Y N	Chills	Y N	Weight Loss	Y N	Vision Problems	Y N
Wear Glasses	Y N	Hearing Loss	Y N	Sinus Problems	Y N	Chest pain	Y N
Difficulty Breathing	Y N	Short of Breath	Y N	Heartburn	Y N	Diarrhea	Y N
Constipation	Y N	Urinary Difficulty	Y N	Joint Stiffness	Y N	Joint Swelling	Y N
Skin Rashes	Y N	Skin Problems	Y N	Seizures	Y N	Memory Loss	Y N
Depression	Y N	Diabetes	Y N	Anemia	Y N	Blood Disorders	Y N
Hay Fever	Y N	Wheezing	Y N				

Patient Signature _____ Reviewed By: _____ Date: _____

Physician Signature _____ Reviewed By: _____ Date: _____

Olympia Orthopaedic Neurosurgery
PATIENT INFORMATION SHEET

Staff only:
Weight: _____
Height: _____
BP: _____
Pain: _____
Age: _____

Date: _____

_____		_____	
Patient Name		Date of Birth	
_____		_____	_____
Street Address		City	State
_____		_____	_____
Home Phone		Work Phone	Cell Phone

<input type="radio"/> Right handed <input type="radio"/> Left handed (Please mark one)
--

_____ Referring Physician _____ City

Name of primary care provider/physician: _____

Are you currently being treated by a chiropractor? No Yes
If yes, name: _____

Are you currently being treated by a physical therapist? No Yes
If yes, name: _____

May we send information about your treatment here to the above practitioners/physicians? No Yes

Explain briefly why you are being seen: _____

Date of injury/onset: _____ Circumstances of injury/onset: _____

Have you ever had a similar problem? No Yes If yes, please describe: _____

Drug Allergies and Reactions (Please list allergy and reaction):

Allergy	Reaction

Are you allergic to any of the following:

- | | | | |
|-----------------|--|----------------|--|
| Shellfish | <input type="radio"/> No <input type="radio"/> Yes | X-ray contrast | <input type="radio"/> No <input type="radio"/> Yes |
| Metal | <input type="radio"/> No <input type="radio"/> Yes | Latex/rubber | <input type="radio"/> No <input type="radio"/> Yes |
| Costume Jewelry | <input type="radio"/> No <input type="radio"/> Yes | Soap | <input type="radio"/> No <input type="radio"/> Yes |
| Iodine | <input type="radio"/> No <input type="radio"/> Yes | Tape | <input type="radio"/> No <input type="radio"/> Yes |

Olympia Orthopaedic Neurosurgery
PATIENT INFORMATION SHEET

Patient Name: _____

Current Medications (please include all prescription, over-the-counter drugs, birth control pills and vitamins)

Name of Medication	Reason	Dose	Frequency

Past Medical History (please check any current or past problems)

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Blood abnormality | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease/attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tick Bites | <input type="checkbox"/> HIV or exposure | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Liver abnormality | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes yr onset _____ | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Back pain child/adult | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Other _____ | |

Blood clot or deep venous thrombosis (DVT)

Do you have a current gum or dental infection? No Yes

Surgery History:

Surgery Name	Surgery Date	Location where performed

- No Yes Have you had surgical complications?
If yes, describe: _____
- No Yes Have you had an adverse reaction to general anesthesia?
If yes, describe: _____
- No Yes Have any immediate family members had an adverse reaction to general anesthesia?
If yes, describe: _____
- No Yes Have you had a blood transfusion? Approximate year: _____
- No Yes Is there any reason you could not receive blood if needed during surgery?
- No Yes Are you pregnant?

Olympia Orthopaedic Neurosurgery
PATIENT INFORMATION SHEET

Patient Name:

Social History

Are you currently: Single Married Separated
 Divorced Widowed Domestic Partner

Are you currently employed? No Yes Occupation: _____

No Yes Do you currently use tobacco? If yes, do you:
 No Yes Smoke cigarettes How many per day? _____ Years of use _____
 No Yes Cigar/pipe How many per day? _____ Years of use _____
 No Yes Chew tobacco How many cans per week? _____ Years of use _____

No Yes Are you a former smoker/tobacco user? If yes, what age did you quit: _____

No Yes Have you ever used recreational/non-medical drugs? If yes, type: _____

No Yes Do you use alcohol? If yes, amount per day or week: _____

Family History (Please describe the health history of your family members)

Relationship	Age (at death if deceased)	Health Status (living or deceased)	Medical problem or cause of death
Spouse			
Mother			
Father			
Child			
Child			
Child			

Olympia Orthopaedic Neurosurgery
PATIENT INFORMATION SHEET

Patient Name: _____

Please mark any of the following you are experiencing:

Constitutional:	Head/Ear/Eyes/Nose/Throat:	Respiratory:
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Coughed blood
<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Headache	<input type="checkbox"/> Asthma/wheezing
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Hearing difficulty	<input type="checkbox"/> Cough
<input type="checkbox"/> Recent infections	<input type="checkbox"/> Eye or mouth dryness	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Problems sleeping	Cardiovascular:	Other:
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Menstrual difficulty
<input type="checkbox"/> Weakness	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Stiff joints
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Swollen joints

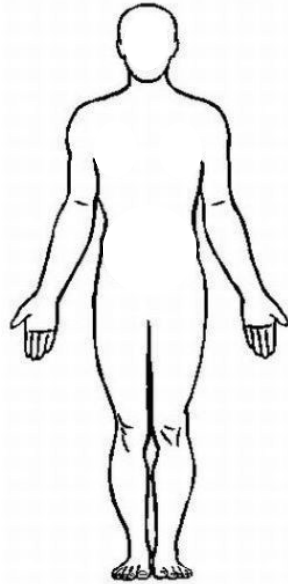
GI/GU:	Neurological:	
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Poor coordination
<input type="checkbox"/> Nausea	<input type="checkbox"/> Impaired thinking	<input type="checkbox"/> Seizure
<input type="checkbox"/> Constipation	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Bloody urine	<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Speech difficulty
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty with taste/smell	<input type="checkbox"/> Blackouts or fainting
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Meningitis, encephalitis
<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Swallowing difficulty
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Back, neck, head injury	<input type="checkbox"/> Sexual function problems
<input type="checkbox"/> Bowel incontinence	<input type="checkbox"/> Depression	<input type="checkbox"/> Decreased attention
<input type="checkbox"/> Black/bloody stools	<input type="checkbox"/> Tremor or shaking	<input type="checkbox"/> Personality changes
	<input type="checkbox"/> Double vision	

Other symptoms you have experienced (please describe):

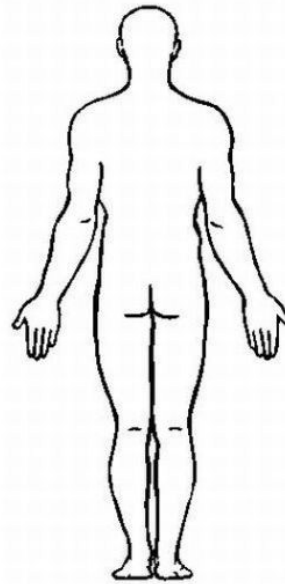
Olympia Orthopaedic Neurosurgery
PATIENT INFORMATION SHEET

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Ache: AAAA Numbness: NNNN Burning: BBBB Stabbing: SSSS Tingling: TTTT
 AAAA NNNN BBBB SSSS TTTT



FRONT



BACK

Please rate your pain on a scale of 1 - 10
1 = none or least amount of pain
10 = most severe pain imaginable

Today:	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
	1	2	3	4	5	6	7	8	9	10
Least:	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
	1	2	3	4	5	6	7	8	9	10
Worst:	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
	1	2	3	4	5	6	7	8	9	10

I attest all information I have provided is true and correct to the best of my knowledge.

 Patient Signature

 Date

 Physician Signature

 Date